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The Development of a Therapeutic Listening Instrument For Allied Health: A Pilot Study

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The Development of a Therapeutic Listening Instrument
For Allied Health: A Pilot Study

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Submitted in Partial Fulfillment of the Requirements for the Degree

Masters of Science in Occupational Therapy

School of Health and Natural Science

Dominican University of California

San Rafael, California

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THE DEVELOPMENT OF A THERAPEUTIC LISTENING INSTRUMENT
FOR ALLIED HEALTH: A PILOT STUDY

This thesis, written under the direction of the candidates' thesis advisor and approved by the Chair of the Masters program, has been presented to and accepted by the Faculty of the Occupational Therapy department in partial fulfillment of the requirements for the degree of Master of Science in Occupational Therapy. The content, project, and research methodologies presented in this work represent the work of the candidates alone.

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Abstract

Occupational therapy education programs need a method for capturing student success in learning the necessary skills of therapeutic listening prior to fieldwork. There are no formalized instruments to measure therapeutic listening knowledge and skills in occupational therapy curriculums. Listening measurement tools that currently exist have been primarily created for other professionals in the medical field. Developing a listening instrument that measures the basic knowledge and skills of students' listening would benefit occupational therapy education programs by determining the need for additional listening training of its students. This thesis study describes a pilot study used to develop a therapeutic listening instrument. The Therapeutic Listening Instrument consisted of listening terminology and clinical scenarios composed of three domains of therapeutic listening to determine participants' application of listening knowledge. The instrument was piloted to experts, clinicians, and students. The results indicated that the instrument is not a reliable and valid tool to measure therapeutic listening. Data collected from the pilot study provided information for further development and refinement of the Therapeutic Listening Instrument.

Introduction

In 2007, 41% of people reported that their healthcare provider did not always listen carefully to them (Healthy People 2020). When healthcare providers use effective listening skills, patient satisfaction increases (Ok, Marks, & Allegrante, 2008). Good communication has been shown to increase clients' emotional health, increase function, and decrease individuals' chronic disease states (Davis, Foley, Crigger & Brannigan, 2008; Jagosh, Boudreau, Steinert, MacDonald, & Ingram, 2011; Simpson et al., 1991). The most common complaints by the public about physicians were related to problems with communication rather than with clinical competency (Simpson et al., 1991). Current research shows positive outcomes are associated with good clinician-patient communication, which has a significant effect on patient satisfaction and adherence to treatment (Bayne, 2011; Denham, et al., 2008; Simpson et al., 1991). Therapeutic listening is one strategy that can be used to improve communication between healthcare practitioners and clients.

Therapeutic listening is one fundamental aspect of the overarching concept of therapeutic communication. Taylor defines therapeutic listening as a "therapist's efforts to gather information from a client in such a way that it promotes greater understanding, validation, and support" (Taylor, 2008, p. 171). Occupational therapists use a client-centered approach to intervention, where the clients play an active role in the direction of therapy (Taylor, 2008). Listening skills are essential for use in client-centered practice and therapeutic use of self. Taylor, Lee, Kielhofner, and Ketkar (2009) found that 80% of clinicians believe that therapeutic use of self is the single most important skill for occupational therapy practice. By using therapeutic listening skills, a clinician will

promote therapeutic use of self to improve the quality of care that clinicians provide; therefore these are essential skills for clinicians to have when entering a healthcare field.

According to Davidson, there are inadequate educational practices relative to therapeutic use of self and most clinicians learn interpersonal communication skills on the job, rather than during their educational program (Davidson, 2011; Taylor et al, 2009). It is the goal of occupational therapy education to provide students with specific values, knowledge, and skills in preparation for fieldwork and entry level practice. Therapeutic use of self is a fundamental skill that should be taught in occupational therapy education, but has not been universally included in the curriculum (Davidson, 2011). The purpose of this research study is to bring awareness to the importance of listening as a core component of teaching therapeutic use of self in occupational therapy education. This research study will focus specifically on providing the field of occupational therapy with a therapeutic listening assessment, which can be a tool for educators and managers to use to evaluate the listening knowledge and skills of students and clinicians. This tool may serve as a means to assess listening skills, and therefore bring awareness to the need for further training in therapeutic listening skills. After a review of the literature on effective listening, communication, and therapeutic listening skills, the common factors defining listening were extracted. The factors were used to develop questions for a pilot therapeutic listening assessment. This assessment was first evaluated and piloted to experts, and then piloted to occupational therapy clinicians and students. The results were analyzed to determine if there was any significant difference in knowledge of listening between groups and where improvements need to be made. The following literature review will discuss therapeutic listening and

why it is important, its impact on healthcare, current listening training programs, and current assessments used to measure listening.

Literature Review

Therapeutic Listening

Therapeutic listening has been defined in many ways. Therapeutic listening is a communication process of gathering information from clients in order to have a better understanding of what the client is experiencing. The goal of therapeutic listening is to allow the client to feel validated for how he or she feels, to provide support for the client's viewpoint, and to allow the client to feel understood during the healthcare information exchange (Taylor, 2008). Relationships that include trust and empathy are conducive to healing (Jagosh et al., 2011). It takes a willingness on the part of the healthcare practitioner to listen and provide time for the client's story to unfold (Churchill & Schenck, 2008). Coulehan (1999) indicated that if clients think the healthcare practitioner is listening and interested in what they have to say, they are willing to share their feelings. Clients who felt their medical practitioner was not listening, withheld information during the consultation process (Watson, Lazarus, & Thomas, 1999). Allowing clients to speak and be listened to is part of the healing process. Therapeutic listening has been shown to be an effective skill for practitioners during this process of healing (Churchill & Schenck, 2008). Thus, therapeutic listening is a useful tool in building trust and showing empathy to clients so that they feel heard and empowered.

There are many terms found in the literature for listening with the intent to be helpful: empathetic listening, guided listening, use of verbal prompts and sounds, and

enrichment questions (Taylor, 2008). Therapeutic listening incorporates the interpersonal use of empathy (Taylor, 2008). Empathetic listening is known as careful and honest listening, which enhances the ability to view the world through another person's eyes (Newson, 2006). When a listener is using empathetic listening, they are not only understanding the words they hear, but understanding the thoughts and feelings that are expressed beyond the spoken words. A therapeutic listener is aware of his or her own body language, eye contact, and use of silence when listening with the intent to understand (Newson, 2006). Guided listening is different from empathetic listening because its goal is to influence what clients say by using summarizing, clarifying, and organizing of what has been said, thus empowering the client in the process (Taylor, 2008). Verbal prompts are found such as "Uh huh", and "Umm" to demonstrate to the client that the healthcare practitioner is listening, and to encourage the client to feel comfortable eliciting more information. This is further encouraged through open-ended enrichment questions starting with would, when, where, what, and how (Taylor, 2008). Enrichment questions are useful for both the client and healthcare provider to gain more pertinent client information (Taylor, 2008).

Therapeutic listening is also commonly known as active listening. Listening is often thought to be a passive skill that happens automatically in communication between two or more people, but people who are good listeners use active listening. This is a skill which needs to be practiced and developed to master (Edwards, 1991; Helsel & Hogg, 2006). Listening to clients' fears and apprehensions are behaviors that clients seek or desire the most from their healthcare practitioner (Simpson et al., 1991). Active listening also includes encouraging, restating, reflecting, validating, and giving feedback (Olsen &

Iwasiw, 1987). As a listener, it is important to understand what is being said. Active listening requires the listener to reflect on what the speaker is saying and to ask questions about what is being said. It is also important to pick up on cues that may represent thoughts or emotions (Olsen & Iwasiw, 1987).

Body language is another important aspect of listening that can be used to gain information about the client. Research suggests that the following connotes effective body language: eye contact, leaning forward, open body language, uncrossed arms, and body movements which imitate the speaker (Cocksedge & May, 2005). Listening in the healthcare profession involves picking up on the cues the patient consciously or unconsciously gives (Cocksedge & May, 2005). A healthcare practitioner's work-related pressures might also affect his/her attitude towards a client, affecting body language and how he/she attends to the cues of a client, as well as the context of the interaction, which can affect the listening process (Cocksedge & May, 2005).

Shipley (2010) stated that listening is one of the oldest healthcare skills and is necessary if meaningful interactions with clients are to be realized. Listening is a multifaceted concept that also consists of cognitive, affective, and behavioral processes (Gearhart & Bodie, 2011). Cognitive processes address the messages that need to be understood, attended, received, and interpreted, all critical components in the therapeutic listening process. The listener is responsible for processing and thinking about the words they are hearing rather than passively hearing what is spoken (Boudreau, Cassell, & Fuks, 2009). Processing includes both affective and behavioral components. Affective processes refer to the motivation of the listener in the effort to attend to a person's emotions and messages. Behavioral processes refer to both the verbal and nonverbal

feedback and responding in an appropriate manner (Gearhart & Bodie, 2011). Examples of verbal characteristics are: using non-judging language, inviting interaction by offering open-ended questions, and valuing others through summary statements, honesty, and use of proper tone of voice. Nonverbal characteristics consist of: eye contact, a mirrored position, open gestures, smiling, nodding, using close proximity, and not rushing off (Gearhart & Bodie, 2011).

Rationale of Therapeutic Listening in Healthcare

Therapeutic listening promotes client satisfaction, increased emotional health, and mutual understanding. When these areas are compromised, there can also be financial repercussions affecting health outcomes and the overall cost of healthcare.

The impact of therapeutic listening on client satisfaction. Listening contributes not only to the healthcare relationship, but studies have shown that a good relationship with the client can contribute to healing (Churchill & Schenck, 2008). A consultation is the initial stage of the relationship building process between the healthcare practitioner and the client. The quality of this relationship has a direct impact on client satisfaction (Bayne, 2011). This is applicable to occupational therapy. Listening is foundational to the consultation process. Ample evidence has revealed that active listening was a key part of this therapeutic process in building rapport with clients resulting in increased client satisfaction (Fassaert, van Dulmen, Schellevis, & Bensing, 2007; Simpson, et al., 1991). Budzi, et al. (2010) found that interpersonal skills, such as listening to the concerns of the client and being attentive during the interaction, led to improved client satisfaction. Marcinowicz, Chlabicz, & Grebowski (2009) examined client satisfaction and found that clients' common criteria for satisfaction was being

listened to and being understood. Clients in this study also felt that when their healthcare practitioner adequately listened to them, their medical problems were resolved in a more timely manner. Client satisfaction with the healthcare relationship also includes aspects of empathy. Empathy is an interpersonal skill, and is a foundational component in the listening process for satisfaction. However, it is lacking in many healthcare communication interactions (Bayne, 2011; Berg, Majdan, Berg, Veloski, & Hojat, 2011). Research has shown that empathy provides the healthcare provider/client relationship with a common understanding and enhances client satisfaction levels (Norfolk, Birdi, & Patterson, 2009). Empathy taps into the emotional side of the consultation process allowing healthcare practitioners to better determine how the client feels, improving the overall client experience (Norfolk et al., 2009). A lack of empathic listening leaves the client dissatisfied with the level of care received (Davis, Foley, Crigger, & Brannigan, 2008). While active listening and interpersonal skills are major factors of satisfaction in the healthcare relationship, research shows that these are important aspects that are often left out of communication skills training (Pederson, 2010).

The impact of listening on health. A quality listening relationship has been associated with beneficial health outcomes for clients (Simpson et al., 1991). Jagosh, Boudreau, Steinert, MacDonald, & Ingram (2011) found that listening can aid in stress and anxiety reduction. According to their study, listening provided an avenue for open communication and emotional release as long as the client had a trusting relationship with the medical professional who listened and encouraged him or her to speak (Jagosh et al., 2011). Listening is more than simply hearing. The client is providing key

information about their state of health. If the healthcare practitioner is willing to take the time to actively listen, a better intervention and health outcome is more probable (Boudreau, et al., 2009). Harris and Templeton (2001) studied breast cancer patients and found that when physicians used positive listening behaviors, the physician-patient relationship was enhanced and contributed to an increase in mental health. Churchill and Schenck (2008) interviewed 50 physicians and listening was the main theme that emerged as promoting a healing relationship. Physicians noted it was important to listen beyond the patient's diagnosis by asking about their lives, rather than their condition. Patients provide important information through their own stories if physicians are willing to take the time to listen.

Therapeutic listening has become a lost art replaced by checklists, computerized forms and standardized questions decreasing the listening opportunity for a client's story to be heard, often prolonging the healing process (Denham et al., 2008). However, if the practitioner takes the time to actively listen to a client's story with undivided attention, he or she will gain valuable insight assisting with the healing process (Churchill & Schenck, 2008; Hovey & Paul, 2007). The quality of the listening component during the communication process facilitates better emotional health and lowered disease states (Davis, et al., 2008; Simpson et al., 1991). Current research has further emphasized the importance of listening *throughout* the medical relationship because it aids in making a correct diagnosis, aids in decreasing the client's suffering, and enables increased client understanding (Bayne, 2011; Churchill & Schenck, 2008).

The impact of listening on client understanding. When healthcare practitioners lack adequate communication skills, they not only fail to extract quality pieces of

information from the client, but they also lose the ability to help the client understand his or her care resulting in low treatment compliance (Denham, Dingman, Foley, Ford, Martins, O'Regan, & Salemendra, 2008). Boudreau et al. (2009) further explained that the healthcare practitioner needs to communicate on a level the client can understand and during a time when he or she is receptive to what is being said. When clients go to see their physician, they often are in a vulnerable state, and in this state they often will withhold information unless they feel listened to (Watson, Lazarus, & Thomas, 1999). When physicians spoke to their patient while the patient was lying down on a medical examination table, undressed, anxious, and distracted, it resulted in the patient not listening or understanding (Ornstein & Baum, 2008). The literature showed that if distractions occur in the listening process, this can result in misinterpreting what has been said, resulting in a poor therapeutic relationship (Boudreau, et al., 2009).

This leads to the consideration and importance of the listening context. Creating a conducive listening environment can help to relieve the anxiety of the client. The context can help the healthcare practitioner to focus on listening with a desired outcome of mutual understanding so that he/she can create an intervention that is effective (Haddon, 2009). Clients are more apt to comply with treatment when they are relaxed and understand what has been said. Clarity of communication is important for a positive therapeutic relationship, leading to fewer malpractice lawsuits (Shipman, 2010).

The impact of listening on healthcare costs. Due to the current economic climate, productivity in healthcare settings is emphasized, placing medical professionals under greater stress to see more clients per day (Ornstein & Baum, 2008). On average, physicians see approximately five clients every hour (Davis et al., 2008). A typical 40-

year medical career results in practitioners completing at least 150,000 client consultations. This means less time is spent listening to clients, creating more room for errors (Watson et al., 1999). With an emphasis on productivity, multi-tasking is typical within the healthcare culture of the United States. This means less time is spent using active listening. It has been found that 77% of client interviews result in the client not stating the reason for the visit (Denham et al., 2008), and approximately 15 % of clients are not properly diagnosed due to the lack of listening (Ornstein & Baum, 2008). When clients are diagnosed improperly, it prolongs client care and adds to the overall cost of healthcare. If this is happening with physicians, it may be assumed that it is happening with other healthcare professions as well.

Healthcare industries are beginning to take notice of the significance that listening to their clients has on healthcare costs (Hall, 2008). One way to increase client loyalty and enhance the medical relationship is through the use of therapeutic listening (Fassaert, Dulmen, Schellevis, & Bensing, 2007). Clients that are loyal and satisfied are less apt to take legal action against their medical provider; therefore, the experience of the client is crucial to a medical facility's bottom line (Hagihara & Tarumi, 2007; Hall, 2008). However, when clients do not feel validated or listened to, they become dissatisfied with service delivery. When dissatisfaction is the result, threat of increases creating additional liability risks and increased expenditures, which contributes to the increase in overall healthcare costs (Hagihara & Tarumi, 2007; Hall, 2008; Lefevre, Waters, & Budetti, 2000).

The impact of listening and litigation. Research shows the primary reason for client lawsuits is poor communication, and many cases could have been avoided if there

had been adequate communication between the healthcare provider and the client (Simpson et al., 1991; Waxman, 2009). The 1999 report from the Institute of Medicine reported nearly 98,000 people die each year in the United States from medical errors resulting from improper client communication (Denham et al., 2008). Denham et al., (2008) further stated that clients are interrupted by their physicians 60 percent of the time during a conversation, resulting in a decreased amount of time spent listening. Medical professionals who fail to listen to a client increase the risk of misdiagnosing the client and increase the risk for negligence (Langslow, 1992).

When medical professionals did not explain or listen to clients, dissatisfaction occurred, increasing the risk for litigation. It is not enough to simply communicate to clients and families; rather it is the quality of the communication that places medical professionals at risk for litigation (Hagihara & Tarumi, 2007). It is reported that on average, four billion dollars in malpractice claims are paid out each year raising the cost of healthcare and impacting healthcare facilities (Hall, 2008). Healthcare providers have the ethical responsibility to listen to their client in order to increase satisfaction, decrease lawsuits, and lower the cost of healthcare (Davis, et al., 2008; Hall, 2008). These findings suggest that using active listening skills during the communication process led to decreased malpractice litigation making it necessary for medical educators to re-examine their medical training practices (Lefevre et al., 2000; Shipman, 2010).

Current Training for Listening and Communication in Healthcare Education

The education system in the United States tends to focus on improving students' speaking skills instead of improving students' listening skills. Helsel & Hogg (2006) claim listening is a communication skill that students have the least amount of instruction

in. Direct instruction in listening skills can lead to desired outcomes (Wolvin & Coakley, 2000). Studies suggest students who have completed therapeutic listening training reported that the training have improved their listening skills at work and in their personal lives (Wolvin & Coakley, 2000). Research has shown that teaching strategies need to be identified so that effective listening can be taught successfully (Beall, Gill-Rosier, Tate, & Matten, 2008). Some key techniques to teaching therapeutic listening are: repetitive practice, performance assessments, immediate feedback, and a clinically meaningful context (Boudreau, et al., 2009). Listening training courses utilized a combination of those components listed above. According to the literature, there are four main techniques for teaching listening skills to students including video recordings, web-based learning, audio recordings, and role-playing (Boudreau, Cassell & Fuks, 2009; Cheon & Grant, 2009; Kluge & Glick, 2006). The following section will report on current teaching techniques for listening and communication skills.

Courses using role-play. Role-play and group process appeared to be the most beneficial part of a listening and empathy training program for third-year medical students (Bayne, 2011). Medical students participated in a six-week course where students role-played as physicians and as clients followed by a discussion of their thoughts and feelings. Their scores on the Consultation and Relational Empathy Scale (CARE) improved significantly indicating that students' empathy increased after the course. This suggests that role-play was a beneficial technique to use for broadening student's clinical empathy and awareness. Another study at Duke University called *Psychosocial Aspects of Care*, utilized role-play to facilitate listening skills training. Forty-nine Doctor of Physical Therapy students were enrolled in the course

during the research study. Significant positive changes were noted in two subtest areas in the Patient-Practitioner Orientation Scale (PPOS) and Tasks of Medicine Scale (TOMS) from pre- to post- intervention indicating more client-centered attitudes. After the study, open-ended questions were administered and indicated students had positive educational experiences. Key concepts learned from this course were awareness of the ‘other’ perspective, how to use active listening, and viewing the patient as an individual (Ross & Haidet, 2011). The qualitative data suggests that the physical therapy students found the course useful in learning about client-centered communication. Both of these studies supported role-play as a successful technique for teaching students about empathy and helping to shape students’ attitudes, which affect their behavior ultimately.

Courses using video recordings. Some researchers argue that traditional methods are challenging for students. For example role-playing in the classroom can be challenging when students are having a hard time with the acting component (Kluge & Glick, 2006). An alternative method to role-play when teaching therapeutic listening is to use a video recording. A study by Olson and Iwasiw (1987) used video-based training methods with Registered Nurses’ (RN) and indicated positive results. The RN’s active listening skills improved significantly. Post baccalaureate RNs attended a communications skills course, which was followed by a test. The test was presented in video format with professional actors and actresses acting out common patient-and-clinician situations. RNs were audio recorded during the test and scored using the Behavioral Test of Interpersonal Skills for Health Professionals (BTIS). The results showed that the RN’s active listening scores increased significantly after this listening skills course (Olson & Iwasiw, 1987). Before training, RNs identified with the patient’s

feelings 30.4% of the time and after training 78.5% of the time (Olson & Iwasiw, 1987). RNs discounted patients' feelings 6.4% of the time before the training and 1.6% of the time after the training (Olsen & Iwasiw, 1987). According to Olsen and Iwasiw (1987) results showed a significant increase in only six weeks in the nurse's active listening skills, suggesting that education programs offered to healthcare practitioners would be beneficial for improving therapeutic listening skills.

One course used a method called Video Inter-Active (VIA), which had actors and actresses acting as patients. The research showed that this method was an effective way for healthcare students to foster therapeutic listening skills (Kluge & Glick, 2006). The findings of this study indicated significant gains in verbal and nonverbal skills in the experimental group. The experimental group would respond appropriately more frequently and scored higher for nonverbal techniques with a group mean of 17.38 compared to the control group mean of 9.88 (Kluge & Glick, 2006). The experimental group scored lower for communication blocks with a mean of 1.72 compared to the control group with a mean of 4.94 (Kluge & Glick, 2006). Therefore, students who learned therapeutic listening skills with the VIA program improved their listening skills compared to students who were not trained with the video.

Courses using web-based learning. The goal of web-based learning is to create didactic learning activities with interactive tests so that students in multiple disciplines can develop active listening skills for effective future communication with their clients. An internet-based course housed on a website titled "Active Listening" has been developed for beginning counseling psychology students. The website was created with the idea that the students can practice active listening in a situation that emulates a

counseling situation. The video-clips are meant to demonstrate the way in which active listening is used. The program was created to teach the students listening knowledge and improve their listening behaviors. The first module showed didactic elements of active listening whereas the second module allowed the student to identify listening skills, and the third module enabled students to practice using therapeutic listening. The results from the survey indicated students' perceptions regarding usability, experience overall, and instructional effectiveness were highly positive. One student mentioned that it tested his or her understanding of active listening in a way that could not be duplicated on paper because the visual component helped him or her to better comprehend and learn what a clinician should be focusing on during a therapeutic conversation (Cheon & Grant, 2009).

Courses with combined methods: role-play and video. In Tiuraniemi, Läärä, Kyrö, & Lindeman's 2011 study, medical students and psychology students participated in role-play as a teaching method for students to learn about interpersonal and communication skills. The other purpose of the role-play was for the students to be able to practice reflection skills including appropriate eye contact, effective use of silence, empathy, and validation. In addition, video was utilized to add a visual aid for teaching communication skills in this study. Results showed that significant changes occurred in the students' communication skills, especially empathy and reflection. Third-year psychology students' self-rated mean communication skills competency was 41.0 at the start of the course, and at the end of the course the mean was 58.8. Fourth-year psychology students started with a mean of 62.2 and ended with a mean of 72.8. Medical students' communication skills mean was 63.2 before the course and 72.0 after the course. Students assessed their own competency and skills before and after the

training. Results show that all student groups improved in their communication skills competency after the course (Tiuraniemi et al., 2011).

Components of Existing Instruments

Throughout the years there has been a gap in instructional methods research that ensures comprehension, practice, and assessments of both behavioral and cognitive components of therapeutic listening (Janusik, 2002). To ensure effective listening training, listening curriculums require assessments in order to evaluate the students' listening skills (Wolvin & Coakley, 2000). According to Boudreau et al., (2009) performance assessments are an essential tool in listening curriculums. The literature provides research on listening assessments that examine listening skills through various methods. The following sections will define the types of assessments being used and the factors being assessed.

Types of listening assessments. Auditory, visual, and written types of assessments are the common instruments used to measure listening skills. Auditory assessments may use audio recordings of conversations to code and assess listening skills. Visual assessments include coding of listening behavior found in recorded video or through observation. Written assessments consist of different types of scales and tests, which are commonly multiple choice questions, Likert scales, or open-ended questions. These categories of instruments assessing listening skills will be further discussed in the following sections.

auditory assessments. The auditory assessments are not a common type of instrument found in the literature. The Behavioral Test of Interpersonal Skills for Health Professionals (BTIS) is an assessment used to examine the interpersonal or interviewing

skills of any health profession student or practitioner. The test consists of 28 common patient and health professional situations, which have been role-played by actors and actresses and recorded on videotape. The subjects respond to each situation and are then audio recorded and scored (Olsen & Iwasiw, 1987). This assessment's focus is more about interpersonal interviewing skills, which does not address specifically the therapeutic components of listening. This assessment has limited research and information. Another type of assessment that can be used by audio recording is the Roter Interaction Analysis System (RIAS). Auditory assessments are not commonly found in the literature. The RIAS is frequently researched and is the most widely used assessment for medical interactions. This assessment is used to code medical dialogues, and can be either audio or video recorded (Roter & Larson, 2002). The RIAS appears to be an adequate assessment. It requires use of recording equipment and highly trained coders to evaluate the recorded dialogue. Therefore, this assessment takes more time and could come at a high cost. The BTIS and RIAS both involve recording, coding, and scoring, which can be very time consuming. Depending on the goal of the user, this approach may not be ideal based on time and cost.

visual assessments. Visual assessments, although time consuming, provide more information based on the ability to examine body language. The RIAS, as described in the previous section, can also be evaluated using video recordings and includes an extensive list of coding categories that assess the listening behaviors in medical consultations (Roter & Larson, 2002). The next described assessment does not specifically measure listening skills, but is a form of a communication evaluation. The Clinical Assessment Simulations (CAS) are structured evaluations of the learner at

selected points in a curriculum. Faculty directly observes a simulation, evaluates students, and documents performance on a data collection form. The objective of this assessment is to evaluate clinical competence of senior medical-surgical nursing students and their ability to report essential communication criteria (Krautscheid, 2008). This assessment is not specifically measuring listening skills. It provides a form of assessment that can be used for therapeutic listening skills. The Active Listening Observation Scale (ALOS-global) is an observation instrument measuring active listening for medical consultations. Active listening is measured by coding the observation based on specific items (Fassaert, van Dulmaen, Schellevid, & Bensing, 2007). The three assessments mentioned in this section could potentially be used to assess listening skills, but the focus is more on medical consultations rather than broader healthcare contexts. These assessments also involve the same type of recording, coding, and scoring as needed in the auditory assessments, which come at a high cost of both time and money.

written assessments. Written assessments are the most common type of instruments used to evaluate listening skills and primarily include self-report instruments. The Medical Communication Competence Scale (MCCS) is a self-report scale used to examine the perception of communication competence in doctor-patient communication (Cegala et al., 1998). Although this assessment is valid, it is only looking at medical communication specific to physicians. It is also only examining dimensions of communication, and only slightly touches on some listening skills. The Watson-Barker Listening test is used to assess listening comprehension in adults by using videotaped materials and a multiple-choice test. The research states that this listening test is not reliable or valid, and is not a recommended tool, in part due to the nature of multiple-

choice questions (Bodie, Worthington, & Fitch-Hauser, 2011). The Active-Empathic Listening (AEL) scale was originally developed to assess the active-empathic listening of salespeople. Although the AEL scale was developed for salespeople, it can be used as a general self-report measure with other individuals as well and found to be a valid measurement of active-empathic listening (Bodie, 2011). The scale includes a self-report 7-point Likert scale that asks participants how frequently they perceive different situations relating to the categories of sensing, processing, and responding (Gearhart & Bodie, 2011). This assessment is a self-report type of an individual's perception of their own listening skills. Although this assessment is closely related to therapeutic listening skills, it is only based on an individual's self perception rather than examining their knowledge and skills needed for clinical practice.

Common Factors Used in Current Assessments

Listening is defined by various listening scholars. Imhof-Janusik (2006) developed an inventory of listening concepts that were broken down into four categories: organizing information, relationship building listening, learning and integrating information, and critical listening. Drollinger et al. (2006) concluded that active-empathic describes listening in categories of sensing, processing, and responding. Cegala et al. (1998) broke down communication into four clusters: information giving, information seeking, information verifying, and socioemotional communication. After review of the literature, three common themes appeared throughout: establishing rapport, organizing information, and nonverbal immediacy language. Establishing rapport is a skill that is essential for building relationships and is used by the clinician to make the client feel comfortable (Taylor, 2008). Organizing information is used primarily to

gather information from the client to best understand their needs and wants, and to collaborate with the client to problem solve through the intervention process. Nonverbal immediacy is closely related to what most know as body language, and is described as the observable nonverbal behaviors used to communicate social accessibility and produce interpersonal closeness (Anderson, Anderson, & Jenson, 1979). The following sections describe the common factors that are being examined in these assessments.

Establishing rapport. Multiple assessments included categories relating to establishing rapport. The ALOS-global includes areas of observation that describe actions of establishing rapport. These items include: is not off hand or hasty, is obviously relaxed and confident, is not detached, adjusts his/her language to that of the patient, listens attentively, creates an open atmosphere during the conversation, and spends time on social talk (Fassaert et al., 2007). The RIAS includes a coding list for: personal remarks, social conversation, laughs, tells jokes, shows concern or worry, reassures, encourages, shows optimism, shows approval, gives compliment, empathy statements, legitimizing statements, partnerships statements, and self-disclosure statements (RIASWorks). The MCCS measures perceptions of socioemotional communication such as using language the patient could understand, being warm and friendly, contributing to a trusting relationship, showing the patient that they cared about him or her, making the patient feel relaxed or comfortable, showing compassion, and being open and honest (Cegala et al., 1998). The AEL scale includes the sensing section that examines areas relating to building rapport, which include sensing what others are not saying, aware of what others imply but to do not say, understand how others feel, and listen for more than just spoken words (Gearhart & Bodie, 2011). These assessments described above

provide multiple factors that have been included in assessments to examine the ability to establish rapport. The mentioned assessments are found to be valid and reliable ways of assessing listening skills and should be considered when developing the assessment questions.

Organizing information. Organizing information is the category that is most commonly used when assessing listening skills. Although the MCCS, focuses more on communication skills, two of the four clusters identified related to organizing information (Cegala et al., 1998). These areas are information seeking and information verifying. Specifically, the categories include reviewing, or repeating important information, making sure patients understand explanations and directions, checking understanding, encouraging patients to ask questions, asking patients the right questions, asking questions in a clear and understandable manner, and using open-ended questions (Cegala et al., 1998). The ALOS-global assesses the organization of information by examining areas such as giving the patient time and space to present the problem, using exploring questions, leading the conversation, and expanding upon the patient's feelings or emotions (Fassaert et al., 2007). The Watson-Barker Listening Test (WBLT) examines five aspects of listening ability: evaluating message content, understanding meaning in conversations, understanding and remembering information in lectures, evaluating emotional meanings in messages, and following instructions and directions (Bodie et al., 2011). AEL is described in three categories: sensing, processing, and responding. Each of these categories contain items to assess different aspects of listening (Gearhart & Bodie, 2011). The items relating to organizing information are the processing and responding sections. The processing section includes areas such as

assuring others that what they say will be remembered, summarizing points of agreement and disagreement, and keeping track of points others make. The responding section includes such things as assuring others that they are being listened to, receptive to their ideas and understanding their positions, and showing they are attending by using body language (Gearhart & Bodie, 2011). Organizing information is essential to provide proper care to clients. The listed assessments have found many ways to examine the ability to organize information, and should be included when evaluating this listening skill.

Nonverbal immediacy. There are two assessments that measure nonverbal immediacy and body language to examine listening skills. The ALOS-global includes areas that assess body language, such as: uses inviting body language, shows not to be distracted during the consultation, is obviously relaxed and confident, is not detached, listens attentively, creates an open atmosphere during the conversation, and expresses understanding nonverbally (Fassaert et al., 2007). The second is the AEL scale, which includes a component that assesses body language. Specifically, the item assesses whether a person shows others he/she is listening by his/her body language (Gearhart & Bodie, 2011). Although nonverbal immediacy and body language are not commonly found in the literature for listening assessments, this is an important skill needed to physically show the client they are being listened to and should be included in the therapeutic listening assessment.

Statement of Purpose

As shown throughout the literature, listening is a critical aspect of the communication process between the healthcare practitioner and the client, and it is an

area that has been well studied (Brown et al., 2011). Studies have shown that without adequate listening skills, the meaningful therapeutic relationship suffers. Client concerns become lost and healing potential is compromised (Harris & Templton, 2001; Shipley, 2010). Poor listening skills that continue to be used in the healthcare relationship has been shown to result in a lack of client understanding, increased healthcare costs, and rising malpractice suits (Boudreau et al., 2009; Shipman, 2010). Despite numerous studies that show listening as a crucial component of communication, quality listening continues to be undervalued in education. It is an area that students, our future healthcare practitioners, get little training in (Helsel & Hogg, 2006). There have been many assessments developed to evaluate listening and communication skills in healthcare practitioners. These assessments examine various areas of listening skills, but no assessment refers specifically to therapeutic listening that can be applied to Allied Health, and specifically occupational therapy.

Although therapeutic listening is a skill needed by healthcare providers, there is a paucity of literature that focuses specifically on therapeutic listening in Allied Health. There is also a lack of research on assessments developed for the occupational therapy clinicians, and more specifically, occupational therapy students. The majority of assessments are designed for nurses, physicians, salespeople, and counselors. There were also few assessments found that were easy to administer and score. Many of the assessments involved recording equipment, coding, and scoring. Due to the gap in research, the purpose of this research is to develop a listening assessment that is easy to use, that specifically measures therapeutic listening skills, and that can be used as a tool to assess therapeutic listening skills of occupational therapy students and clinicians.

Through the development and pilot of the therapeutic listening instrument we answered the following research questions:

1. Do the Listening Skills questions have a strong inter-item correlation for the experts?
2. Do the Listening Skills questions inter-item correlation increase or decrease when it is piloted to the clinicians and students, in comparison to the expert group?
3. Is the listening instrument sensitive enough to detect differences in listening skills and knowledge between groups?
4. Is there a positive correlation between the Listening Skills and Communication Terminology sections?

Definitions

Therapeutic communication

When a therapist asks the right questions at optimal times and in ways that facilitate information-sharing and client self-reflection (Taylor, 2008).

Therapeutic listening

A therapist's efforts to gather information from a client to promote greater understanding, validation, and support (Taylor, 2008). It involves empathic listening, guided listening, verbal prompts and sounds, and enrichment questions (Taylor, 2008).

Therapeutic use of self

A personal, individualized, subjective decision-making process that incorporates knowledge and interpersonal skills within an interaction (Taylor, 2008).

Therapeutic relationship

The client and therapist interaction that is socially defined and personally interpreted (Taylor, 2008).

Theoretical Framework

The Person-Environment-Occupation Model

The Person-Environment-Occupation Model (PEO) was developed in the early 1990s by Law, Strong, Rigby, Stewart, Letts, and Cooper. Law and associates used environment and behavioral theories to explore the dynamic and complex interaction between the person and the environment to determine the influence on occupational performance (Dunbar, 2007). The model interlinks the person, the environment, and the person's occupations using a transactional approach rather than a linear approach. The goal is to obtain cohesion, or a good fit, between the person and the environment to reach an ideal outcome of occupational performance (Law et al., 1996).

The person brings inherent factors such as emotional, physical, spiritual, and cognitive qualities into the interaction process. The environment encompasses the person's personal, physical, and social contexts, which in turn prompts a response by the person (Law et al., 1996). When the environment changes, the person must adapt his/her behavior in order to carry out the desired occupation, thus influencing occupational performance. Law and colleagues explain that occupational performance depends on the congruency, or fit, between the person and his/her environment (Law et al., 1996). The roles of a person also affect this relationship due to his/her dynamic qualities and variety of experiences over the lifespan. A person's roles are not only influenced by the personal qualities he or she currently possesses, but also by the environmental influences

on the person as these roles change. Because people hold several roles simultaneously, this model considers all of their attributes and suggests that they be viewed holistically (Cole & Tufano, 2008; Law et al., 1996).

The environment itself has an influence on how a person behaves. The environmental aspect is broad and includes domains such as cultural, institutional, educational, personal, physical and social (Law et al., 1996). Under the PEO model, it is necessary to understand the environmental context in which the person is performing because the resulting behavior affects occupational performance (Cole & Tufano, 2008).

Occupation is all encompassing as the combination of both the person's activities and tasks. The American Occupational Therapy Association (AOTA) Occupational Therapy Practice Framework defines occupation in a broad sense to encompass everyday activity (AOTA, 2008). Due to the variety of inferences on the meaning of occupation in past models, the developers of the PEO model incorporate the subcategories of activity and task under the definition of occupation (Law et al., 1996). While activity under this model is the sole engagement in an action as part of the person's daily experiences, task is defined as a set of these activities. Under this model, occupations are engaged in by the person to fulfill his or her needs for self-expression and intrinsic fulfillment (Law et al., 1996).

For this study, we considered two people: the client and the occupational therapy student. The client provides the information and the occupational therapy student gathers the information and listens to what is being said. Both are important in respect to the PEO model. Although both are separate individuals, each come together in a shared therapeutic environment. While both the roles of the client and the student will change

over time, this study focused on the importance of the role of the occupational therapy student in particular, in relation to the client. The occupational therapy student will eventually take on the role of a clinician. This makes it important to examine his or her behaviors related to key skills needed to establish a therapeutic environment.

The goal of PEO is to have a best fit between the person the environment and the occupation for optimal occupational performance. Our goal is to establish a trusting relationship within a therapeutic environment, in which each person expresses his/her needs, feels listened to and is mutually understood. As described in the literature reviewed, attainment of mutual understanding through the listening process leads to an increase in client satisfaction, and an increase in client willingness to participate in the intervention. This meant that if the healthcare provider and the client are able to communicate in a safe and effective environment using therapeutic listening, the occupational outcomes improved because the person and the environment had a closer fit.

The Intentional Relationship Model

The intentional relationship model conceptualizes the process that is involved with therapeutic use of self (Taylor, 2008). Taylor states that “therapeutic use of self involves a highly personal, individualized, subjective decision-making process” (2008, p.45). The model was developed to appease the need for a conceptual model based on the therapeutic relationship, as this is a key component of occupational therapy practice. The purpose of the model is to explain therapeutic use of self, how to develop a therapeutic relationship, and how occupational therapy clinicians can facilitate occupational performance in their clients (Taylor, 2008).

The model was developed based on theories of psychotherapy, where there is interpersonal relating between a therapist and a client (Taylor, 2008). In this psychotherapy model, the interpersonal relating is a central focus and is the only activity occurring in therapy. In occupational therapy, one must consider more than just the interpersonal relating. This intentional relationship model explains that the therapeutic relationship is only one part of occupational therapy intervention and is intended to be used in conjunction with other models, depending on the individual client's wants and needs. The model is only intended to fill the gap of knowledge in establishing successful relationships in occupational therapy (Taylor, 2008).

The elements of the intentional relationship model include the client, the interpersonal events that occur during therapy, the therapist, and the occupation (Taylor, 2008). The client is central to the model and includes their interpersonal characteristics, such as situational and enduring characteristics. The interpersonal events of therapy include the communication, reactions, processes, tasks, or circumstances that occur and have an impact on the therapeutic relationship. The therapist is responsible for the interpersonal skill base, the therapeutic modes, and the capacity for interpersonal reasoning. The therapeutic modes include advocating, collaborating, empathizing, encouraging, instructing, and problem-solving. The desired occupation is the chosen activity chosen to focus on. The therapeutic relationship is key to this model, connecting the therapist and client. This relationship is influenced by what the client and therapist both bring to the relationship, as well as other extrinsic factors that affect the relationship. The therapist is responsible for continually evaluating the relationship and

using interpersonal reasoning to promote an optimal therapeutic relationship (Taylor, 2008).

The intentional relationship model applies to occupational therapy and this study by supporting the importance of therapeutic use of self throughout the intervention process. This model fills the gap in occupational therapy literature, providing a model that promotes therapeutic use of self. It discusses the importance of this skill in occupational therapy and that it “must be developed, reinforced, monitored, and refined” (Taylor, 2008, p. 45). After review of the literature, a gap in occupational therapy education indicates the need for more education on therapeutic use of self. This model could be implemented and taught in occupational therapy education programs to promote therapeutic use of self, including therapeutic listening, in entry-level clinicians.

Ethical Considerations

Approval from the Institutional Review Board (IRB) was obtained prior to implementation of this study. The Occupational Therapy Code of Ethics and Ethics Standards (2010) as set forth by The American Occupational Therapy Association (AOTA, 2010), is a professional document created to guide the conduct of its professionals while promoting a high level of care. Occupational therapy members uphold these standards in their relational practice with clients, and extend the ethical principles and standards of conduct in all relationships. This includes the care used with research participants. Beneficence, autonomy/confidentiality and veracity, are ethical components included in this document and were used to guide the research values of this study.

According to AOTA's Code of Ethics, beneficence is a principle of care that demonstrates an act of service, which provides "a concern for the well-being and safety of the recipients" (AOTA, 2010, p. 3). The act of beneficence requires a high level of care in which researchers prevent conditions that might cause harm to participants. In our research, this was demonstrated by abiding by ethical guidelines and standards during the consent process. Participants were provided a participant bill of rights describing the risks and benefits of the study, as well as the rights of the participants during the study.

Autonomy follows the principle of self-determination in which research participants have free will to withdraw from the research project at any time during the study (AOTA, 2010). The paper-based and online assessments completed during the piloting segments of the study were anonymous. Data collected in the study, was protected under the guiding principle of confidentiality. Here, any information provided by participants had all personal identifiers removed from the data. All data was stored in the secured, locked office of the thesis advisor.

Veracity stems from the virtues of truthfulness, honesty and a sincere representation of the study (AOTA, 2010). The researchers were truthful in the representation, collection and reporting of all data used throughout the study. Care by the researchers was taken to ensure data reporting and findings were objective and accurate. All three ethical components foster a relationship of trust between the researchers and participants, and guided this study to promote ethical standards and participant protection during the course of this study.

Method

Design

A quantitative non-experimental, survey content analysis research design was used for this research study to establish reliability and validity of a new scale. Content analysis is a technique that allows for the coding of responses in a quantitative manner that allows for organizing answers into a meaningful set of categories to enable statistical analysis (Lavrakas, 2008). This design, in conjunction with an understanding of scale development through an approach described by DeVellis, guided the research methods used for instrument development. According to DeVellis (2012), the steps to scale development include: 1) determine clearly what it is you want to measure; 2) generate an item pool; 3) determine the format for measurement; 4) have initial item pool reviewed by experts; 5) consider inclusion of validation items; 6) administer items to a development sample; 7) evaluate the items; and 8) optimize scale length. These 8 steps of scale construction facilitated the development process. By developing this instrument, we will be adding to the knowledge on therapeutic listening for occupational therapy students and professionals.

STUDY 1

The first study consisted of reliability analysis of the original 27 items based on experts only.

Participants

The participants in Study 1 were comprised of experts. Experts were defined as occupational therapists known to be master clinicians who specialize in listening therapeutically within psychosocial areas of treatment.

Expert recruitment. Purposive and convenience sampling were used to recruit participants. The experts were recruited by sending emails to occupational therapy experts in the mental health area of practice in Northern California. An initial email was sent to experts explaining the purpose of our study. A total of nine occupational therapists agreed to serve as experts. The demographic information for the expert participants appears in Table 1.

Table 1*Demographic Variables*

	Experts		Clinicians		Students with Listening Training		Students without Listening Training	
	<i>(N= 9)</i>		<i>(N= 14)</i>		<i>(N= 33)</i>		<i>(N= 42)</i>	
	N	%	N	%	N	%	N	%
Gender								
Male	0	0%	0	0%	2	6.1%	4	9.5%
Female	9	100%	14	100%	31	93.9%	38	90.5%
Age								
19-24	0	0%	0	0%	7	21.2%	25	59.5%
25-30	1	11.1%	1	7.1%	19	57.6%	11	26.2%
31-40	1	11.1%	3	21.4%	4	12.1%	1	2.4%
41-55	2	22.2%	5	35.7%	1	3.0%	3	7.1%
55+	5	55.6%	5	35.7%	0	0%	0	0%
Not Reported					2	6.1%	2	4.8%
Practice Area								
Private Hospital	0	0%						
County Hospital	1	11.1%	1	7.1%				
Veterans Affairs (VA)	1	11.1%	0	0%				
Community Program	3	33.3%	2	14.3%				
Private Clinic	0	0%	3	21.4%				
Academic Setting	2		0	0%				
Schools	0	0%	1	7.1%				
Other	2	22.2%	4	29%				
Undergraduate Major								
Health Science					11	33.3%	20	47.6%
Kinesiology					5	15.2%	5	4.8%
Psychology					5	15.2%	0	0%
Exercise Science					0	0%	5	4.8%
Other					8	24.2%	8	19.0%
Not Reported					3	9.1%	10	23.8%
Formal Training in Active Listening								
Yes			8	57.1%				
No			6	42.9%				

Materials

Instrument Development. Following the steps to scale development by DeVellis (2012), a listening instrument was developed. First, it was determined that the goal of the instrument was to measure both listening knowledge and skills. Based on the literature, an item pool was generated that was based on three factors believed to be critical components of therapeutic listening: 1) establishing rapport; 2) organizing information; and 3) non-verbal immediacy. The format of the instrument included two sections: Knowledge of Communication Terminology and Listening Skills. After determining the format, the listening instrument was developed and anonymously piloted online to experts. The instrument was revised based on the results of expert responses and then was further piloted to occupational therapy clinicians and undergraduate and graduate occupational therapy students in Northern California. An additional section at the end of the instrument allowed for qualitative participant feedback on the questions and format of the instrument to provide additional information for the researchers on the instrument development. The collected feedback gave information on the quality and clarity of the questions. After data collection, the items were evaluated.

Knowledge of Communication Terminology section. The Knowledge of Communication Terminology assessment section of the instrument was designed to provide baseline information on whether participants had the ability to define communication terms used in listening in a multiple-choice format, insuring that the questions had a right and wrong answer. There were ten questions that assessed listening Knowledge of Communication Terminology: judging, open-ended questions, restatement,

reflection, validation, encouragement, placating, primary accurate empathy, mind reading, and giving feedback.

Listening Skills section. After review of the literature, it was determined that when assessing Listening Skills, multiple-choice was not recommended because of the dynamic nature of the task. These types of questions were found to be either right or wrong, which contradicts the nature of listening skills (Bodie, Worthington, & Fitch-Hauser, 2011). Therefore, a 5-point Likert-style format was used to assess listening in the Listening Skills section of the instrument. Based on the defined listening factors of establishing rapport, organizing information, and nonverbal immediacy, the initial pilot included 27 clinical scenarios that allowed participants to apply their comprehension of listening skills in order to choose a therapeutic listening response on a continuum from “not therapeutic” to “very therapeutic.”

Procedure

The experts were emailed a link to the initial pilot instrument. The email sent to the experts included necessary information regarding the study and who to contact with questions. Consent was implied if they completed the online instrument.

The data collected for the experts' responses were collected via an online Google Drive survey. This survey was designed so that all responses remained anonymous. The survey consisted of 10 Knowledge of Communication Terminology questions, 27 Listening Skills questions, and an area for qualitative feedback about the instrument. Once all the data was collected, the responses were recorded for further data analysis.

The distribution of the respondents' gender, age, OT area of practice, and undergraduate major were collected for each of the four groups: experts, clinicians,

students with listening training, and students without listening training. Refer to Table 1 for this demographic information.

Data Analysis

The SPSS (Statistical Package for the Social Sciences) windows version 12.0 (SPSS, Inc., Chicago, IL) was used to input and analyze quantitative data of the instrument. The original 27 Listening Skills Items appear in Appendix I. For data analysis purposes, questions 1, 5, 9, 10, 14, 16, 17, 19, 20, 22, 23, 24, and 26 were reverse coded to reflect the most therapeutic response (See Appendix I).

The instrument was analyzed to determine item analysis correlation using a Pearson correlation. The Pearson correlation indicates whether the items are related to each other, therefore indicating if they were measuring the same thing throughout the instrument. Internal consistency and homogeneity were determined by calculating Cronbach's alpha. Cronbach's alpha is defined as "the most commonly applied statistical index for internal consistency" (Portney & Watkins, 2009, p. 606).

Results

The results from the expert participants were analyzed to identify the questions that were not well received. If there was 90% agreement on the Likert responses, the questions remained in the assessment. If there was less than 90% agreement, the questions were eliminated. Since the answers are Likert style, some responses totaled 90% by grouping together two adjacent response choices. For example, in some cases 45% of the experts answered "very therapeutic" and 55% of the experts marked "generally therapeutic." In cases like this, as long as the answers were in agreement (therapeutic or not therapeutic) and were adjacent to each other, the responses were noted

and remained in the assessment. This was acceptable since the nature of listening in specific contexts is not always right or wrong.

Based on additional feedback from the experts, the Listening Skills section of the initial pilot of the instrument was slightly revised from a total of 27 clinical scenario questions down to 15 based on consensus of expert responses. The fifteen remaining Listening Skills questions were separated into five questions per corresponding listening factor category of establishing rapport, organizing information, and nonverbal immediacy, established in the initial pilot to the experts.

Research Question #1: *Do the Listening Skills questions have a strong inter-item correlation for the experts?*

Nine experts completed the 27-item instrument, however one of the experts did not complete the entire pilot assessment and was therefore excluded from further analysis. The percentage of experts that chose each response appears in Appendix I along with the item correlation and Cronbach's alpha if deleted. The Cronbach's alpha for the experts (N=8) was 0.848, indicating high internal consistency.

Twelve items were removed based on the item correlation and the agreement of expert responses. Of those items, eight items were eliminated based on a total correlation of 0.00 and below, and are indicated in Table 2. In addition to the item-total correlation, four items were eliminated based on poor expert agreement. After removal of these items, the Cronbach's alpha of the remaining 15 items increased to a 0.912.

STUDY 2

The second study consisted of reliability and correlation analysis of the 10 Knowledge of Communication Terminology items and the remaining 15 Listening Skills

items and was piloted to clinicians, students with listening training, and students without listening training.

Participants

Clinicians were defined as practicing occupational therapists in the Bay Area. The students were defined as occupational therapy students at a Northern California university, split into two groups: 1) students at the end of their second semester of Psychosocial Aspects of Occupational Therapy course; and 2) students in the beginning of their first semester of Psychosocial Aspects of Occupational Therapy course. The Psychosocial Aspects of Occupational Therapy is a year-long course that focuses on the study of psychosocial aspects of human occupation and disability in occupational therapy and includes listening training curriculum. This listening training involved at least 14 weeks of intensive study of listening in a therapeutic context, both didactic and experiential learning, using role-play and video. For the purpose of this study, student Group 1 is described as students with listening training and student Group 2 is described as students without listening training. There were no restrictions on participation for this study regarding gender, age, race, or ethnicity. All groups were recruited by means of purposive and convenience sampling.

Clinician recruitment. Occupational therapy clinicians were recruited by sending emails to 100 practicing occupational therapists listed as fieldwork educators for a Northern California university. Participation of clinicians was obtained in the same manner as the experts through an anonymous online piloting of the instrument. A total of 14 clinicians completed the online pilot.

Student recruitment. In order to recruit occupational therapy student participants, an email was sent to the professors in an occupational therapy program at a Northern California university requesting permission to present in their classrooms to ask for participation. Presentations were given to four cohorts of occupational therapy classes in order to recruit occupational therapy students. A total of 75 occupational therapy students volunteered.

Materials and Procedures

Clinician data collection. The clinicians were emailed the second pilot containing the 15 question-version of the instrument through the private online Google Drive survey. The email sent to the clinicians included necessary information regarding the study and who to contact. It was implied consent if they completed the online instrument.

Student data collection. The student pilots were administered at two different times to two different groups: a group before listening training and a group after listening training, assuming that participant responses may have been affected by the future content of the course they were enrolled in. The instrument was first piloted to students with listening training at the end of a spring semester, therefore completing the year-long Psychosocial Aspects of Occupational Therapy course. The instrument was then piloted during the first two weeks of the fall semester for the students without listening training. The participants completed an informed consent agreement prior to the administration of the pilot measure in order to address ethical considerations. All participants were informed of their rights to dismiss themselves at any time or part of the pilot for any reason. There was an opportunity for the participants to ask questions prior

to starting. Participants were informed that their information would remain confidential, and they were instructed not to write their name on their response forms. After completion, the pilot assessments were placed in an envelope in the front of the room and number coded to ensure participant confidentiality. After coding, the data was stored in the thesis advisor's office.

Data Analysis

The responses were coded as “right” or “wrong” for the Communication Knowledge questions, receiving either a zero or one point for their response. For the Listening Skills questions, answers were coded from 1 to 5 based on the five-point Likert scale with a coded score of 5 indicating a more therapeutic response to the clinical scenario. An ANOVA of the composite scores was used to compare the mean scores between groups.

Results

Research Question #2: *Do the Listening Skills questions inter-item correlation increase or decrease when it is piloted to clinicians and students, in comparison to the expert group?*

The remaining 15 items were piloted to clinicians (N=14) and students (N=75), with a total of (N=89). The student group consisted of students with listening training (N=33) and students without listening training (N= 42). The Cronbach's alpha for this group decreased to .339, suggesting that the internal consistency of the scale did not hold between groups.

Research Question #3: *Is the listening instrument sensitive enough to detect differences in listening skills and knowledge between groups?*

Composite scores for all four groups were created. Each Listening Skill question was assumed to have a correct answer, with the correct answer receiving 5 points. The composite score was created by summing allotted points from the 15 items together, resulting in scores ranging from 15-75. A score of 15 indicates the lowest possible score and a score of 75 represents the highest possible score. Table 2 includes the composite scores for the Knowledge of Communication Terminology and Listening Skills sections for all groups. One-way ANOVA revealed no significant difference among experts, clinicians, students with listening training, and students without listening training for the Knowledge of Communication Terminology questions $F(3, 94) = 2.02, p > .05$, indicating no significant differences in knowledge of listening terms between groups. When comparing means between groups for the Listening Skills questions, results, $F(3, 94) = 1.04, p > .05$, indicated no significant differences between groups.

Table 2
Composite Score Differences

		Experts	Clinicians	Students with training	Students without training
Communication Terminology Questions:	Mean	7.33	6.07	7.06	6.36
	SD	1.32	2.16	1.71	1.65
Listening Skills Questions:	Mean	63.44	60.42	62.48	61.86
	SD	8.69	5.15	3.43	3.85

Research Question #4: *Is there a positive correlation between the Listening Skills and Knowledge of Communication Terminology sections?*

A Pearson Correlation was conducted and indicated the correlation between the Knowledge of Communication Terminology and Listening Skills sections as $r(87) = .18$, $p > .05$. This suggests that there is no correlation between the Knowledge of Communication Terminology and Listening Skills questions of the instrument.

Discussion

Our first research hypothesis was that there would be internal consistency among groups for the Listening Skills items. Though there was internal consistency among the experts for the Listening Skills items, it did not transfer well into the second study on the clinician and student participants. The high internal consistency from the expert responses could have been by chance, as there were a low number of participants and a larger sample size is needed to confirm these results for a larger population. There was weak support for our hypotheses that there would be internal consistency from the experts to the group of clinicians and students.

Our second research hypothesis was that the instrument would be sensitive enough to detect the differences in Listening Skills and Knowledge of Communication Terminology between groups. This hypothesis was incorrect. This suggests that either the items are too obvious, meaning anyone interested in healthcare would be able to tell the difference between therapeutic and non-therapeutic encounters, or the participants already have a greater emotional intelligence than the average population. Both of these sections in the instrument were developed by the researchers and were not standardized.

One possible method to validate our instrument would be to incorporate an existing standardized assessment.

Our third research hypothesis was that there would be a positive correlation between the Listening Skills and Knowledge of Communication Terminology sections. Again, our hypothesis was incorrect. These results may suggest that, although an individual may know vocabulary terms, this does not mean that they understand the skills related to listening. This may suggest that the communication vocabulary terms are not correlated with listening skills.

According to the experts, items seemed to be adequate for determining appropriate listening, but they were not worded to determine differences between experts, clinicians, and students. This may be because people who may choose a healthcare profession may already have had an understanding of therapeutic use of self through prior education to understand these scenarios. So perhaps this would be a good measure of showing aptitude for occupational therapy such as a career choice aptitude test. This would have to be tested, but this is where this instrument may be better used to find out which people have affinity for going into the allied health field.

Limitations and Further Research

This study has several limitations. The sample size of participants does not represent the broader field of occupational therapy clinicians and students, as it was piloted to clinicians and students in the Bay Area. A broader sample size, preferably a minimum of 100 participants per group, as well as encompassing a larger geographic area, would be beneficial so that the results can generalize to a larger population of occupational therapy clinicians and students. A larger sample size of the expert

population and collaborating with this population throughout the development process of the instrument would be useful in determining the reliability and validity of the questions in the instrument. Also, larger male sampling would further expand knowledge of gender differences in the assessment of therapeutic listening.

The instrument was assessed in a survey and paper-based format, which does not adequately assess other aspects of listening, such as tone of voice and body language. It was also limited in capturing responses that were cognitive based, rather than behaviorally based. Although the therapeutic listening instrument was created as a baseline evaluation, listening encompasses many nonverbal behaviors that may not be captured through a paper-based assessment. Through further development of this instrument, video-taping could easily demonstrate nonverbal behaviors that a paper-based assessment can not.

The questions developed for this instrument were specifically piloted to occupational therapy clinicians and students in an occupational therapy program, limiting the generalizability of this instrument in the Allied Health field. In addition, some questions were only based on occupational therapy practice, when the instrument should encompass a variety of clinical scenarios in the healthcare field. Further research and development is needed in order to develop an instrument that can be generalized to other professions in the Allied Health field. For the Knowledge of Communication Terminology section in the instrument, the questions were vocabulary-based, and deemed to not to be a true reflection of therapeutic listening knowledge. Further research is needed to determine effective strategies for assessing listening knowledge.

When developing the instrument, there were originally 27 Listening Skills questions that were piloted to the experts, which were reduced to 15 Listening Skills questions after the first pilot. Revision should have taken place after the pilot was administered to all groups. Lastly, the instrument that was developed was not compared to another standardized tool measuring therapeutic listening; therefore there is no method to validate the instrument. Further research is necessary to develop and standardize the tool. Once further developed, it is implied that the instrument should be compared to an already standardized tool.

Further research is needed in order to address the limitations of this study. Results of this pilot study also indicate that further development is necessary to create a more valid therapeutic listening instrument, which would benefit OT students, as well as other Allied Health programs. A broader sample from various Allied Health programs, other than occupational therapy, could compare differences in listening among Allied Health professions. Another study could examine if responses are affected by other factors, such as cultural differences.

Conclusion

The purpose of this study was to develop an assessment of therapeutic listening knowledge and skills and to suggest that more instruments were needed to assess specific therapeutic listening skills of occupational therapy students. The assessments found in the literature provided many examples of ways to examine listening skills. Although there was some good information found, a large gap in the data indicated that there were limited instruments that examined therapeutic listening specifically for Allied Health students and professionals. The instruments that are currently being used for healthcare

practitioners are time consuming and potentially costly to use. The goal of this research study was to develop and pilot a therapeutic listening instrument. Through the development process, the limitations discovered will provide knowledge for future development of a more valid instrument for use in Allied Health. Healthcare students and professionals would benefit from an instrument that is easy to use, timely to administer, and focuses specifically on measuring individual's knowledge of therapeutic listening. Once additional instruments are developed, it may be apparent that more listening training programs should be integrated into healthcare education. If all healthcare students and professionals understand therapeutic listening and incorporate these skills into practice, there may be many positive outcomes such as improved client care, and satisfaction, leading to better overall health outcomes.

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Appendix A



December 21, 2012

Linda Roybal
Suzanne Schwind,
Elizabeth Szoboszlay
Brittnee Witham
Occupational Therapy Department

Dear Linda, Suzanne, Elizabeth, Brittnee:

I have reviewed your proposal (entitled, Development of an Instrument to Measure Active Listening in Health Care Students and Professionals) submitted to the Dominican University Institutional Review Board for the Protection of Human Subjects (IRBPHS Application, #10088). I am approving it as having met the requirements for expedited review.

In your final report or paper please indicate that your project was approved by the IRBPHS and indicate the identification number.

I wish you well in your very interesting research effort.

Sincerely,



Martha Nelson, Ph.D. Chair, IRBPHS

cc: Janis Davis

Institutional Review Board for the Protection of Human Subjects
Office of the Associate Vice President for Academic Affairs 50 Acacia Avenue, San
Rafael, California 95901-2298 415-257-1310
www.dominican.edu

Appendix B

Expert Recruitment Email

Dear Expert:

We are occupational therapy students working on our Master's thesis at Dominican University of California. Our area of research is active therapeutic listening. Currently, we are in the process of working on a paper-based assessment using questions to assess students' knowledge of therapeutic listening skills. Our research will also be using video taped interactions to assess listening behaviors.

Due to your professional reputation and expertise, we would greatly appreciate your feedback on the questions we will be piloting in our study. Your opinions and suggestions will be held in high regard.

If you agree to be our expert, please click on the attached link to access the assessment. It should take approximately 10 minutes. **We would appreciate it if you would read the questions and respond to them based on your own clinical reasoning.** We are primarily looking for inter rater reliability on the response to each item.

Your responses will be completely confidential as well as anonymous.

At the end of the assessment, we would appreciate it if you would leave comments on our word choices, example scenarios, or anything else you feel might be helpful for us as our thesis adviser wants to use this as a test of her students' listening knowledge. We appreciate your help, and your suggestions will be considered as we revise our assessment for future use in our study. We know you have a busy schedule, but if at all possible, it would be very helpful if the assessment were completed prior to February 19th.

Sincerely,

Linda Roybal, Brittnee Witham, Suzanne Schwind, Elizabeth Szoboszlay

Appendix C

Clinician Recruitment Email

Dear Occupational Therapy Professional,

We are occupational therapy graduate students from Dominican University of California. We are working under the guidance of Dr. Janis Davis for our Master's thesis research study. We are developing and piloting a listening instrument that we have created to determine whether it can detect knowledge of listening skills.

We would truly appreciate your help and expertise in completing this assessment for our thesis project. The link at the bottom of this email will take you to the online pilot assessment, which should take approximately 15 minutes to complete. There is also an area at the end of the assessment to input any comments or suggestions that might help us move forward with our study. Your responses are completely anonymous, and there is no right or wrong score. We simply would just like for you to provide answers you feel best represents the situation.

Completing the assessment is completely voluntary. Clicking on the attached link and completing the assessment, will serve as your agreed upon consent to participate in this study.

Thank you for helping us further our research on listening. Should you want to learn about the outcomes of this study, please contact Dr. Janis Davis at Janis.Davis@dominican.edu

Sincerely,

Linda Roybal, Suzanne Schwind, Elizabeth Szoboszlay, and Brittnee Witham

Click the link below to access the pilot assessment: Please take the assessment by Friday April 19th so that we are able to compute the data in a timely manner. Thank you.

Appendix D

DOMINICAN UNIVERSITY of CALIFORNIA**LETTER OF PERMISSION TO DUC FACULTY**

RE: PRESENTATION OF RESEARCH PROJECT

Dear Professor:

Our thesis research group would like to take a few minutes to speak with the students in your class about our study. We are trying to recruit students from various departments to participate in our project, which examines interpersonal behaviors. We are requesting your permission to speak briefly about our project to your class and to hand out a flyer about our study to your students at a time that is convenient for you.

We would only need 5 minutes of class time to summarize our project, ask for volunteers, and hand out a flyer with our contact information to participate in our study. This project is an important part of our graduate research requirement as occupational therapy majors at Dominican. Dr. Janis Davis of the Department of Occupational Therapy is supervising our research.

If you have questions about the project you may contact us through email at linda.roybal@students.dominican.edu. If you have further questions you may also contact Dr. Janis Davis at (415)-458-3788. The Institutional Review Board for the Protection of Human Subjects at Dominican University has approved this project and can be contacted at (415) 257-0168 if you have any further questions.

If our request to present to the students in your class meets with your approval, please sign this letter below, and please return the letter in the enclosed stamped self-addressed envelope. A timely response is appreciated due to our research deadlines.

We will then contact you to arrange a convenient time for presenting to your class.

Thanks for your assistance with our research project.

Sincerely,

Linda Roybal, Suzanne Schwind, Elizabeth Szoboszlay, Brittnee Witham

Department of Occupational Therapy
Dominican University of California
50 Acacia Avenue
San Rafael, CA 94901
linda.roybal@students.dominican.edu

I agree with the above request to have your thesis group present on your research study and to hand out a flyer for participation in the study.

Signature/Department

Date

Contact number/email: _____

Class meeting dates/times appropriate to present to your class:

Appendix E

DOMINICAN UNIVERSITY of CALIFORNIA**CONSET TO PARTICIPATE**Purpose and Background:

Brittnee Witham, Linda Roybal, Elizabeth Szoboszlay and Suzanne Schwind, graduate students, and faculty advisor Janis Davis in the Department of Occupational Therapy at Dominican University of California, are conducting a research study designed to examine students' listening behaviors.

I am being asked to participate in this study because I am an occupational therapy student at Dominican University of California.

Procedures:

If I agree to participate in this study, the following will occur:

1. I will be asked to complete a paper-based pilot instrument.
2. I will be briefed on the purpose of this pilot study.
3. I will also be informed that my information will remain confidential and will be reminded not to write my name on the instruments. All documents will be coded and only the investigators will have access to the names of individual participants. These names will be kept in a locked cabinet of the thesis advisor, Dr. Janis Davis.
4. There will be an opportunity for me to ask any questions prior to the start of the session.
5. I will not be personally judged on what I say or how I respond during the questions.
6. The assessment session will begin once all questions have been answered and all participants are ready to start. Once the instrument session is completed, I will be asked to place any written materials in an envelope.
7. I will be notified ahead of time of my rights to dismiss myself at any part of the test for any reason without penalty.
8. Upon request, I can receive a written summary of the relevant findings and conclusions of this project. Such results may not be available for six to nine months after the start of the study.

Risks and/or Discomforts:

1. I understand my participation does not involve any physical risks, but may involve psychological discomfort due to the nature of the questions being asked.
2. I will be providing information of a personal nature and I have the right to refuse to answer any question that causes me distress or that I deem to be an invasion of my privacy. I have the right to withdraw from this study at any time without any adverse effects.

Benefits:

There will be no direct benefits to me from participating in this study, although I may gain a better understanding regarding listening skills and I will be contributing to the body of knowledge of active listening.

Questions: I have talked with the researchers about this study and have had my questions answered. If I have any further questions, I may contact Linda Roybal at: linda.roybal@students.dominican.edu or her research supervisor, Janis Davis, at Janis.Davis@dominican.edu or at 415-458-3788.

If I have any questions or comments about participation in this study, I should talk first with the researcher and the research supervisor. If for some reason I do not wish to do this, I may contact the Dominican University of California Institutional Review Board for the Protection of Human Subjects (IRBPHS), which is concerned with the protection of volunteers in research projects. I may reach the IRBPHS Office by calling (415) 257-1389 and leaving a voicemail message, by FAX at (415) 257-0165 or by writing to the IRBPHS, Office of the Associate Vice President for Academic Affairs, Dominican University of California, 50 Acacia Avenue, San Rafael, CA 94901.

Consent:

I have been given a copy of this consent form, signed and dated, to keep.
 PARTICIPATION IN RESEARCH IS VOLUNTARY. I am free to decline to be in this study or withdraw my participation at any time without fear of adverse consequences.
 My signature below indicates that I agree to participate in this study.

SUBJECT'S SIGNATURE

DATE

SIGNATURES OF RESEARCHERS

DATE

Appendix F

DOMINICAN UNIVERSITY of CALIFORNIA**RESEARCH PARTICIPANT'S BILL OF RIGHTS**

Every person who is asked to be in a research study has the following rights:

To be told what the study is trying to find out;

To be told what will happen in the study and whether any of the procedures, drugs or devices are different from what would be used in standard practice;

To be told about important risks, side effects or discomforts of the things that will happen to her/him;

To be told if s/he can expect any benefit from participating and, if so, what the benefits might be;

To be told what other choices s/he has and how they may be better or worse than being in the study;

To be allowed to ask any questions concerning the study both before agreeing to be involved and during the course of the study;

To be told what sort of medical treatment is available if any complications arise;

To refuse to participate at all before or after the study is stated without any adverse effects. If such a decision is made, it will not affect his/her rights to receive the care or privileges expected if she/he were not in the study;

To receive a copy of the signed and dated consent form;

To be free of pressure when considering whether she/he wishes to agree to be in the study.

If you have other questions regarding the research study, you should ask the researcher or her/his advisor. You may also contact The Dominican University of California Institutional Review Board for the Protection of Human Participants by telephoning the Office of Academic Affairs at (415) 257-0168 or by writing to the Associate Vice President for Academic Affairs, Dominican University of California, 50 Acacia Avenue, San Rafael, CA. 94901.

Appendix G

Expert Pilot Assessment**ASSESSMENT OF LISTENING**

Demographic Information:

Circle One: Male Female

Age: _____

Practice Area: _____

Have you had any training in Active Listening? Yes No

Section I

In the following table, find an example on the right that matches the communication term on the left.

1 Judging

- a. "Oh, it will all work out fine, don't worry."
- b. "You seem to get mad about little things."
- c. "You look very sad today."
- d. "You're sad because your friend didn't call you?"

2 Open-Ended Question

- a. "You're sad because your friend didn't call you?"
- b. "So, you want your parents to understand you better, correct?"
- c. "I bet you were just tired."
- d. "What did you think about the event?"

3 Restatement

- a. "So, you want your parents to understand you better, correct?"
- b. "I bet you were just tired."
- c. "You're sad because your friend didn't call you?"
- d. "What did you think about the event?"

4 Reflection

- a. "I bet you were just tired."
- b. "Tell me more about that."
- c. "You look very sad today."
- d. "Thank you for sharing that with me."

5 Validation

- a. "Thank you for sharing that with me."
- b. "When you picked up the toys, you are helping everyone in the room."
- c. "Oh, it will all work out fine, don't worry."
- d. "I bet you were just tired."

6 Encouragement

- a. "When you picked up the toys, you are helping everyone in the room."
- b. "Tell me more about that."
- c. "Thank you for sharing that with me."
- d. "Oh, it will work out fine, don't worry."

7 Placating

- a. "What did you think about the event?"
- b. "You seem to get mad about little things."
- c. "I bet you were just tired."
- d. "Oh, it will work out fine, don't worry."

8 Primary Accurate Empathy

- a. "You're sad because your friend didn't call you?"
- b. "You look very sad today."
- c. "Tell me more about that."
- d. "When you picked up the toys, you are helping everyone in the room."

9 Mind Reading

- a. "So, you want your parents to understand you better, correct?"
- b. "I bet you were just tired."
- c. "You look very sad today."
- d. "You seem to get mad about little things."

10 Giving Feedback

- a. "Thank you for sharing that with me."
- b. "What did you think about the event?"
- c. "You seem to get mad about little things."
- d. "When you picked up toys, you are helping everyone in the room."

Section II

There is no such thing as a perfect response when talking with people. However, in a setting where you are trying to help someone, some responses are more therapeutic or helpful than others. The following questions will ask about therapeutic listening. Please read the short scenario and circle the number above the term that best describes the health care professional's response.

Establishing Rapport

1. A health care professional is meeting a client for the first and wants to establish rapport. The professional has introduced him/herself and the speaker states, "I don't feel so good." The professional responds, "You don't look so good either".

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

2. A health care professional is meeting a patient for the first time in an acute care unit for persons with mental illness. During the initial assessment the patient tells the health care professional he hears voices telling him he is in trouble. The health care professional responds: "That must be very frightening. How is this affecting you?"

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

3. A health care professional is interviewing a person who was recently paralyzed. This person believes life is no longer worth living and wants to do away with himself. The health care professional responds: "I don't have the right or power to stop you from doing anything to yourself. However, I have seen people with paralysis lead very satisfying and productive lives. If you decide to see what's out there for you, I will work very hard to help you meet your life goals."

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

4. A patient comes into a health care professional's office and appears angry. The health care professional states, "It seems like you are very upset, would you like to talk about it?"

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

5. A health care professional is working in a fast pace facility. The health care professional has been working on wheelchair transfers with Mr. Smith, and today comes into his room and immediately states, "Okay, Mr. Smith, let's stand up."

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

6. A patient is getting ready to be discharged, and has many questions before leaving the hospital. The health care professional states, "Tell me your concerns about going home."

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

7. A client with schizophrenia expresses that she is hearing threatening voices and is very scared. The health care professional states, "It is very normal to feel scared when you feel threatened."

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

8. A health care professional is having a conversation with an elderly client. After the health care professional asks the patient a question about her stroke two years ago, the client does not answer. Before repeating the question, the health care professional gives time and waits for a response.

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

9. A health care professional is seeing a depressed consumer for the first time in a mental health clinic. As the patient is waiting for the therapist to come into the room, the patient overhears the therapist talking in the hall to an angry patient. After 15 minutes, the therapist comes into the patient's room and sighs, and while looking at the chart states, "So what are we seeing you for today?"

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

Organizing Information

1. A health care professional is talking with a swimmer who just revealed she is depressed because she broke her shoulder. The health care professional responds: "Is there anything you would like to discuss?"

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

2. A health care professional is working with a mother whose son was just diagnosed with autism. The mother is reporting on her son's lack of socializing with other children at the park and how this distresses her. The health care professional responds: "So, you are concerned that your son will not be able to make friends?"

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

3. A health care professional is having a conversation with a client who is expressing that he had a horrible week and lists everything that went wrong. Once the client was finished, the healthcare professional summarized his interpretation of what the client was saying.

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

4. A client is discussing her symptoms with a healthcare professional, and states that she has not been feeling well all day. The health care professional states, "Tell me more about what you are feeling."

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

5. A health care professional is discussing goals with a patient who has early signs of dementia, and asks the patient what he wants to work on. The client states, "I really want to paint." The health care professional states, "We will see, is there anything else?"

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

6. A patient was very upset with the hospital staff for denying her request to have a cigarette, and expresses this to a specific health care professional. The healthcare professional responds by stating, "So why do you think they said this?"

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

7. A client came to the health care professional to discuss his severe depression, and states, "I am not able to get out of bed, and am upset all the time." The health care professional states, "Have you been eating?"

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

8. An anxious client is expressing concerns about going back to work, and states, “My co-workers will never respect me, and I am concerned I will not be able to perform my job after my injury.” The healthcare professional responds: “It seems you worry about too much, you’ll be fine.”

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

9. A healthcare professional is working with a child with ADHD and asks what she would like to do. The child states three things that she is very interested in: jump roping, playing with her friends on the playground, and getting better at spelling. The healthcare professional writes down the activities on a whiteboard while verbally repeating each activity to reassure the child that he understands what she wants to do.

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

Non-Verbal Immediacy

1. A health care professional enters a patient’s room at an inpatient facility. The patient is sitting up in bed and the health care professional takes a seat next to him in a chair. The patient begins explaining how sad it is that his family has not come to visit during his hospital stay. The health care professional makes eye contact with the patient occasionally but, while looking out the window, complains to the patient that there is too much commotion outside the window, and states, “Isn’t this noise driving you crazy? Now, what were you saying?”

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

2. A 10 year-old was referred to the clinic. During the first session, the health care professional discusses the types of activities that the child enjoys and is motivated to perform. She explains that she enjoys horseback riding. While she is talking, the health care professional slouches back into the chair and crosses his arms across his chest.

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

3. A patient has just acquired a traumatic brain injury and is very irritable towards any medical professional. He prefers to only engage with his family members. When the health care professional enters the room he begins to scream: "Get out! I don't need you in here!" The health care professional starts to nod, to let him know that she understands his wishes.

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

4. A patient is meeting with the health care professional to learn how to get up out of a chair to use a walker. As the patient stands and grasps the walker she asks, "Now what?" while the health care professional chats with the nurse in the room and points the patient to the door.

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

5. A healthcare professional is conducting a paper and pen assessment with a client who is sitting in a bed. The healthcare professional is waiting for the client to finish, while standing up close by with arms crossed.

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

6. The patient is sitting at the edge of the bed getting ready to get up to use his walker. In response to the health care professional's question about pain, the client states, "I experienced moderate to severe pain this morning." The health care professional responds: "Mr. Johnson, those slippers you are wearing seem very unsafe. We should get you some non-skid hospital socks."

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

7. After weeks of not walking, the patient begins to take steps independently. The patient gives the health care professional eye contact. In response, the health care professional looks directly at the patient and smiles.

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

8. When a healthcare professional first meets her client, she comes in the room greeting the client with a smile. The healthcare professional continues to ask the client how he is doing while reading the patient's chart.

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

9. A healthcare professional is working with a client who has mental illness. The client is expressing something very distressful and begins to cry. The healthcare professional sits down in a chair in front of the client and makes eye contact.

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

Appendix H

Clinician and Student Pilot Assessment**ASSESSMENT OF LISTENING**

Demographic Information:

Circle One: Male Female

Age: _____

Undergraduate Major/ Practice Area: _____

Have you had any training in Active Listening? Yes No

Section I.

In the following questions, find the best answer below that matches the communication term.

1. Judging
 - a. "Oh, it will all work out fine, don't worry."
 - b. "You seem to get mad about little things."
 - c. "You look very sad today."
 - d. "You're sad because your friend didn't call you?"

2. Open-Ended Question
 - a. "You're sad because your friend didn't call you?"
 - b. "So, you want your parents to understand you better, correct?"
 - c. "I bet you were just tired."
 - d. "What did you think about the event?"

3. Restatement
 - a. "So, you want your parents to understand you better."
 - b. "I bet you were just tired."
 - c. "You're sad because your friend didn't call you?"
 - d. "What did you think about the event?"

4. Reflection
 - a. "I bet you were just tired."
 - b. "Tell me more about that."
 - c. "You look very sad today."
 - d. "Thank you for sharing that with me."

5. Validation
 - a. "Thank you for sharing that with me."
 - b. "When you picked up the toys, you are helping everyone in the room."
 - c. "Oh, it will all work out fine, don't worry."
 - d. "I bet you were just tired."

6. Encouragement
- “When you picked up the toys, you are helping everyone in the room.”
 - “Tell me more about that.”
 - “Thank you for sharing that with me.”
 - “Oh, it will work out fine, don’t worry.”
7. Placating
- “What did you think about the event?”
 - “You seem to get mad about little things.”
 - “I bet you were just tired.”
 - “Oh, it will work out fine, don’t worry.”
8. Primary Accurate Empathy
- “You’re sad because your friend didn’t call you.”
 - “You look very sad today.”
 - “Tell me more about that.”
 - “When you picked up the toys, you are helping everyone in the room.”
9. Mind Reading
- “So, you want your parents to understand you better, correct?”
 - “I bet you were just tired.”
 - “You look very sad today.”
 - “You seem to get mad about little things.”
10. Giving Feedback
- “Thank you for sharing that with me.”
 - “What did you think about the event?”
 - “You seem to get mad about little things.”
 - “When you picked up toys, you are helping everyone in the room.”

Section II.

There is no such thing as a perfect response when talking with people. However, in a setting where you are trying to help someone, some responses are more therapeutic or helpful than others. The following questions will ask about therapeutic listening. **Please read the short scenario and circle the number above the term that best describes the health care professional's response.**

1. A health care professional is meeting a client for the first time and wants to establish rapport. The professional has introduced him/herself and the speaker states, "I don't feel so good." **The professional responds, "You don't look so good either."**

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

2. A health care professional is meeting a patient for the first time in an acute care unit for persons with mental illness. During the initial assessment the patient tells the health care professional he hears voices telling him he is in trouble. **The health care professional responds: "That must be very frightening. How is this affecting you?"**

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

3. A patient comes into a health care professional's office and appears angry. **The health care professional states, "It seems like you are very upset, would you like to talk about it?"**

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

4. A client with schizophrenia expresses that she is hearing threatening voices and is very scared. **The health care professional states, “It is very normal to feel scared when you feel threatened.”**

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

5. A health care professional is having a conversation with an elderly client. After the health care professional asks the patient a question about her stroke two years ago, the client does not answer. **Before repeating the question, the health care professional gives time and waits for a response.**

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

6. A health care professional is working with a mother whose son was just diagnosed with autism. The mother is reporting on her son’s lack of socializing with other children at the park and how this distresses her. **The health care professional responds: “So, you are concerned that your son will not be able to make friends?”**

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

7. A health care professional is having a conversation with a client who is expressing that he had a horrible week and lists everything that went wrong. **Once the client was finished, the healthcare professional summarized his interpretation of what the client was saying.**

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

8. A client is discussing her symptoms with a healthcare professional, and states that she has not been feeling well all day. **The health care professional states, "Explain in more detail about what you are feeling."**

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

9. A health care professional is discussing goals with a patient who has early signs of dementia, and asks the patient what he wants to work on. The client states, "I really want to paint." **The health care professional states, "We will see. Is there anything else?"**

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

10. A healthcare professional is working with a child with ADHD and asks what she would like to do. The child states three things that she is very interested in: jump roping, playing with her friends on the playground, and getting better at spelling. **The healthcare professional writes down the activities on a whiteboard while verbally repeating each activity to reassure the child that he understands what she wants to do.**

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

11. A 10 year-old was referred to the clinic. During the first session, the health care professional discusses the types of activities that the child enjoys and is motivated to perform. She explains that she enjoys horseback riding. **While she is talking, the health care professional slouches back into the chair and crosses his arms across his chest.**

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

12. A patient has just acquired a traumatic brain injury and is very irritable towards any medical professional. He prefers to only engage with his family members. When the health care professional enters the room he begins to scream: "Get out! I don't need you in here!" **The health care professional starts to nod, to let him know that she understands his wishes.**

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

13. A healthcare professional is conducting a paper and pen assessment with a client who is sitting in a bed. **The healthcare professional is waiting for the client to finish, while standing up close by with arms crossed.**

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

14. After weeks of not walking, the patient begins to take steps independently. The patient gives the health care professional eye contact. **In response, the health care professional looks directly at the patient and smiles.**

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

15. A health care professional is working with a client who has mental illness. The client is expressing something very distressful and begins to cry. **The healthcare professional sits down in a chair in front of the client and makes eye contact.**

Circle the number below that describes the degree that this response is therapeutic.

1	2	3	4	5
Not therapeutic	Generally not therapeutic	Somewhat therapeutic	Generally therapeutic	Very therapeutic

This completes the pilot assessment. Thank you for your participation. Please take a few minutes to let us know what you thought. Any feedback is greatly appreciated.

1. Which questions were confusing? In what way were they confusing?

2. Are there questions that you thought should be reworded?

3. Other comments or recommendations:

Appendix I

Expert Pilot Assessment Results

	Question:	Response					Corrected Item- Total Correlation	Cronbach's Alpha if Item Deleted
		1	2	3	4	5		
1	A health care professional is meeting a client for the first time and wants to establish rapport. The professional has introduced him/herself and the speaker states, "I don't feel so good." The professional responds, "You don't look so good either."	1	2	3	4	5	.742	.836
		55.6%	44.4%	0%	0%	0%		
2	A health care professional is meeting a patient for the first time in an acute care unit for persons with mental illness. During the initial assessment the patient tells the health care professional he hears voices telling him he is in trouble. The health care professional responds: "That must be very frightening. How is this affecting you?"	1	2	3	4	5	.681	.834
		0%	0%	11.1%	22.2%	66.7%		

**3	A health care professional is interviewing a person who was recently paralyzed. This person believes life is n longer worth living and wants to do away with himself. The health care professional responds: "I don't have the right or power to stop you from doing anything to yourself. However, I have seen people with paralysis lead very satisfying and productive lives. If you decide to see what's out there for you, I will work very hard to help you meet your life goals."	1	2	3	4	5	.805	.823
		0%	22.2%	11.1%	44.4%	22.2%		
4	A patient comes into a health care professional's office and appears angry. The health care professional states, "It seems like you are very upset, would you like to talk about it?"	1	2	3	4	5	.899	.823
		0%	0%	22.2%	22.2%	55.6%		
**5	A health care professional is working in a fast pace facility. The health care professional has been working on wheelchair transfers with Mr. Smith, and today comes into his room and immediately states, "Okay, Mr. Smith, let's stand up."	1	2	3	4	5	-.004	.852
		33.3%	66.7%	0%	0%	0%		

**6	A patient is getting ready to be discharged, and has many questions before leaving the hospital. The health care professional states, "Tell me your concerns about going home."	1	2	3	4	5	.305	.847
		0%	11.1%	22.2%	44.4%	22.2%		
7	A client with schizophrenia expresses that she is hearing threatening voices and is very scared. The health care professional states, "It is very normal to feel scared when you feel threatened."	1	2	3	4	5	.773	.825
		0%	11.1%	22.2%	33.3%	33.3%		
8	A health care professional is having a conversation with an elderly client. After the health care professional asks the patient a question about her stroke two years ago, the client does not answer. Before repeating the question, the health care professional gives time and waits for a response.	1	2	3	4	5	.334	.845
		0%	0%	0%	33.3%	66.6%		

**9	A health care professional is seeing a depressed consumer for the first time in a mental health clinic. As the consumer is waiting for the therapist to come into the room, the consumer overhears the therapist talking in the hall to an angry patient. After 15 minutes, the therapist comes into the consumer's room and sighs, and while looking at the chart states, "So what are we seeing you for today?"	1	2	3	4	5	.168	.848
		88.9%	11.1%	0%	0%	0%		
**10	A health care professional is talking with a swimmer who just revealed she is depressed because she broke her shoulder. The health care professional responds: "Is there anything you would like to discuss?"	1	2	3	4	5	-.225	.857
		11.1%	77.8%	11.1%	0%	0%		

11	A health care professional is working with a mother whose son was just diagnosed with autism. The mother is reporting on her son's lack of socializing with other children at the park and how this distresses her. The health care professional responds: "So, you are concerned that your son will not be able to make friends?"	1	2	3	4	5	.487	.839
		0%	22.2%	44.4%	22.2%	11.1%		
12	A health care professional is having a conversation with a client who is expressing that he had a horrible week and lists everything that went wrong. Once the client was finished, the healthcare professional summarized his interpretation of what the client was saying.	1	2	3	4	5	.831	.822
		0%	22.2%	11.1%	22.2%	44.4%		
13	A client is discussing her symptoms with a healthcare professional, and states that she has not been feeling well all day. The health care professional states, "Explain in more detail about what you are feeling."	1	2	3	4	5	.751	.827
		0%	22.2%	0%	22.2%	55.6%		

14	A health care professional is discussing goals with a patient who has early signs of dementia, and asks the patient what he wants to work on. The client states, "I really want to paint." The health care professional states, "We will see, is there anything else?"	1	2	3	4	5	.068	.856
		44.4%	44.4%	0%	11.1%	0%		
**15	A patient was very upset with the hospital staff for denying her request to have a cigarette, and expresses this to a specific health care professional. The healthcare professional responds by stating, "So why do you think they said this?"	1	2	3	4	5	.632	.834
		0%	44.4%	22.2%	33.3%	0%		
**16	A client came to the health care professional to discuss his severe depression, and states, "I am not able to get out of bed, and am upset all the time." The health care professional states, "Have you been able to practice your arm lifts?"	1	2	3	4	5	-.033	.852
		77.8%	22.2%	0%	0%	0%		

**17	An anxious client is expressing concerns about going back to work, and states, "My co-workers will never respect me, and I am concerned I will not be able to perform my job after my injury." The healthcare professional responds: "It seems you worry about too much, you'll be fine."	1	2	3	4	5	.000	.849
		100%	0%	0%	0%	0%		
18	A healthcare professional is working with a child with ADHD and asks what she would like to do. The child states three things that she is very interested in: jump roping, playing with her friends on the playground, and getting better at spelling. The healthcare professional writes down the activities on a whiteboard while verbally repeating each activity to reassure the child that he understands what she wants to do.	1	2	3	4	5	.842	.825
		0%	0%	22.2%	0%	66.7%		

**19	A health care professional enters a patient's room at an inpatient facility. The patient is sitting up in bed and the health care professional takes a seat next to him in a chair. The patient begins explaining how sad it is that his family has not come to visit during his hospital stay. The health care professional makes eye contact with the patient occasionally but, while looking out the window, complains to the patient that there is too much commotion outside the window, and states, "Isn't this noise driving you crazy? Now, what were you saying?"	1	2	3	4	5	-.218	.854
88.9%	11.1%	0%	0%	0%				

20	A 10-year-old was referred to the clinic. During the first session, the health care professional discusses the types of activities that the child enjoys and is motivated to perform. She explains that she enjoys horseback riding. While she is talking, the health care professional slouches back into the chair and crosses his arms across his chest.	1	2	3	4	5	.701	.840
		77.8%	22.2%	0%	0%	0%		
21	A patient has just acquired a traumatic brain injury and is very irritable towards any medical professional. He prefers to only engage with his family members. When the health care professional enters the room he begins to scream: "Get out! I don't need you in here!" The health care professional starts to nod, to let him know that she understands his wishes.	1	2	3	4	5	.702	.831
		0%	11.1%	22.2%	55.6%	11.1%		

**22	A patient is meeting with the health care professional to learn how to get up out of a chair to use a walker. As the patient stands and grasps the walker she asks, "Now what?" while the health care professional chats with the nurse in the room and points the patient to the door.	1	2	3	4	5	.000	.849
		100%	0%	0%	0%	0%		
23	A healthcare professional is conducting a paper and pen assessment with a client who is sitting in a bed. The healthcare professional is waiting for the client to finish, while standing up close by with arms crossed.	1	2	3	4	5	.231	.847
		44.4%	55.6%	0%	0%	0%		
**24	The patient is sitting at the edge of the bed getting ready to get up to use his walker. In response to the health care professional's question about pain, the client states, "I experienced moderate to severe pain this morning." The health care professional responds: "Mr. Johnson, those slippers you are wearing seem very unsafe. We should get you some non-skid hospital socks."	1	2	3	4	5	-.028	.853
		44.4%	55.6%	0%	0%	0%		

25	After weeks of not walking, the patient begins to take steps independently. The patient gives the health care professional eye contact. In response, the health care professional looks directly at the patient and smiles.	1	2	3	4	5	.334	.845
		0%	0%	0%	33.3%	66.7%		
**26	When a healthcare professional first meets her client, she comes in the room greeting the client with a smile. The healthcare professional continues to ask the client how he is doing while reading the patient's chart.	1	2	3	4	5	-.687	.891
		22.2%	22.2%	44.4%	0%	11.1%		
27	A health care professional is working with a client who has mental illness. The client is expressing something very distressful and begins to cry. The healthcare professional sits down in a chair in front of the client and makes eye contact.	1	2	3	4	5	.863	.828
		0%	0%	22.2%	11.1%	66.7%		